Senate

General Assembly

File No. 110

February Session, 2014

Senate Bill No. 191

Senate, March 25, 2014

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT CONCERNING HEALTH INSURANCE COVERAGE OF ORALLY AND INTRAVENOUSLY ADMINISTERED MEDICATIONS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective January 1, 2015*) Each insurance company, hospital service corporation, medical service corporation, health care center, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues in this state individual health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes and that provide coverage for intravenously administered medications for the treatment or palliation or therapeutic intervention for the prevention of disabling or life-threatening chronic diseases shall provide coverage for orally administered medications for such treatment, palliation or intervention on a basis no less favorable than intravenously administered medications.

Sec. 2. (NEW) (*Effective January 1, 2015*) Each insurance company, hospital service corporation, medical service corporation, health care

center, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues in this state group health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes and that provide coverage for intravenously administered medications for the treatment or palliation or therapeutic intervention for the prevention of disabling or life-threatening chronic diseases shall provide coverage for orally administered medications for such treatment, palliation or intervention on a basis no less favorable than intravenously administered medications.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2015*	New section
Sec. 2	*January 1, 2015*	New section

INS *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 15 $	FY 16 $
State Comptroller - Fringe Benefits (State Employees and Retiree Health Accounts)	GF, TF - Uncertain	See Below	See Below

Municipal Impact:

Municipalities	Effect	FY 15 $	FY 16 $
Various Municipalities	Uncertain	See Below	See Below

Explanation

The bill will result in a cost to the state employee and retiree health plan (state plan)[1], municipalities, and the state, for providing coverage for orally administered medications no less favorably than intravenously (IV) administered medications for certain diseases. The cost to the state plan, municipalities, and the state pursuant to the federal Affordable Care Act (ACA) will be the result of waiving co-pays for those individuals with certain disease who are prescribed an orally administered medication for which there is an equivalent IV administered medication and for which a co-pay applies. The bill does not specify what diseases the cost parity applies to. Therefore, it is uncertain how many individuals this bill would apply to in the state plan, municipal plans or exchange plans and the resulting fiscal impact.

[1] The state employee and retiree health plan is a self-insured health plan. Pursuant to federal law, self-insured health plans are exempt from state health mandates. However, the state has traditionally adopted all state health mandates. Total number of covered lives as of March 2014 = 207,099.

The state employee and retiree health plan covers medically necessary oral and IV medications. IV medications are traditionally administered on an inpatient basis for which there is no co-pay and the costs are billed to the medical plan. In contrast, orally administered medications are traditionally administered on an outpatient basis under the pharmacy benefit plan and are subject to the following co-pays[2]:

	Acute Medications- Participating Retail Pharmacy	Acute Medications- Non - Participating Retail Pharmacy	Health Enhancement Program Only- Chronic Condition- Related Maintenance Medications- Mail Order	Maintenance Medications (Mail Order Required after 1st 30 Day Fill at Retail Pharmacy)
Generic	$3 - $5	20%	$0	$0 - $5
Preferred Brand Name	$6 - $20	20%	$5	$0 - $10
Non-Preferred Brand Name	$6 - $35	20%	$12.50	$0 - $25

Municipal Impact

As previously stated, the bill may increase costs to certain fully insured, municipal plans that do not currently adhere to the coverage requirements of the bill. The coverage requirements may result in an uncertain increased premium cost when municipalities enter into new health insurance contracts after January 1, 2015. In addition, many municipal health plans are recognized as "grandfathered" health plans under the ACA.[3] It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA. Pursuant to federal law, self-insured health plans

[2] In general, co-pays are based on active versus retired status and date of retirement. There is no co-pay for orally administered chemotherapy. (*Source*: State Of Connecticut Pharmacy Benefit Plan as of July 1, 2013).

[3] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.

are exempt from state health mandates.

The State and the federal ACA

Lastly, the ACA requires that, the state's health exchange's qualified health plans (QHPs)[4], include a federally defined essential health benefits package (EHB). The federal government is allowing states to choose a benchmark plan[5] to serve as the EHB until 2016 when the federal government is anticipated to revisit the EHB. It is uncertain what the fiscal impact to the state pursuant to the ACA will be as it is uncertain how many individuals in exchange plans will be impacted.

While states are allowed to mandate benefits in excess of the EHB, the federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage. State mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB for 2014-2015 unless they are already part of the benchmark plan.[6] However, neither the agency nor the mechanism for the state to pay these costs has been established.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to 1) inflation 2) the number of covered lives in the state, municipal and exchange health plans, and 3) the utilization of services.

[4] The state's health exchange, Access Health CT, opened its marketplace for Connecticut residents to purchase QHPs from carriers, with coverage starting January 1, 2014.
[5] The state's benchmark plan is the Connecticare HMO plan with supplemental coverage for pediatric dental and vision care as required by the ACA.
[6] *Source*: Dept. of Health and Human Services. *Frequently Asked Questions on Essential Health Benefits Bulletin* (February 21, 2012).

OLR Bill Analysis

SB 191

AN ACT CONCERNING HEALTH INSURANCE COVERAGE OF ORALLY AND INTRAVENOUSLY ADMINISTERED MEDICATIONS.

SUMMARY:

This bill requires certain health insurance policies that cover intravenously administered medications for the treatment, palliation, or therapeutic intervention for preventing disabling or life-threatening chronic diseases to also cover orally administered medications for the same purposes. Coverage for the orally administered medications must be no less favorable than coverage for the intravenously administered medications.

The bill applies to individual and group policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage under an HMO plan. Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2015

BACKGROUND

Related Federal Law

The federal Patient Protection and Affordable Care Act (P.L. 111-148) allows a state to require health plans sold through the state's health insurance exchange to offer benefits beyond those included in the required "essential health benefits," provided the state defrays the cost of those additional benefits. The requirement applies to benefit mandates enacted after December 31, 2011. Thus, the state is required to pay the insurance carrier or enrollee to defray the cost of any new

benefits mandated after that date.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 15 Nay 4 (03/13/2014)